CALIFORNIA COALITION FOR MENTAL HEALTH

California Coalition for Mental Health Budget Position

February 22, 2011

1. **Reducing Medi-Cal benefits will result in cost shifts.** Co-morbid health conditions in mental illness are common. Limiting consumer prescriptions to a hard cap of only six a month while imposing another hard cap limit of 10 physician visits annually is shortsighted and will be more costly. Mental health consumers should not have to choose whether to treat their diabetes, high-blood pressure, heart medications cholesterol, Chronic Obstructive Pulmonary Disease (COPD) or treatment for smoking cessation. In addition, the additional proposed higher co-pays and proposed diminished cash benefits will most likely result in medication non-compliance that will lead to increased emergency room visits, hospitalizations and/or arrest and incarceration.

OPPOSE: 10% provider rate cuts, 10 physician visit hard caps, increased co-payments, and medically necessary prescription drug limits.

2. **Reducing the SSI/SSP grant will result in cost shifts.** Twenty-five percent of adults receive SSI/SSP benefits because of a mental illness and depend upon those benefits to pay for food, utilities and rent. They experience tremendous difficulty securing housing at the current benefit levels, and they will experience even more difficulty if the SSI/SSP benefit level is reduced. In most cases rents exceed benefits checks. Those individuals who have a serious mental illness and are unable to secure affordable housing will likely become homeless, use inpatient care and/or become involved in the criminal justice system.

OPPOSE: Reducing SSI/SSP Grants.

3. **Eliminating Adult Day Health Care will result in cost shifts.** The proposal to eliminate Adult Day Health Care will disenroll 37,000 current beneficiaries, negatively impacting those individuals as well as their family members and/or caregivers. In 2006, over 40% of those enrolled had a mental health diagnosis solely or a mental health diagnosis in addition to their primary health concern. Adverse effects to the quality of life of these beneficiaries under this proposal will result in cost shifts to Medi-Cal by increasing expenditures for emergency rooms and skilled nursing facilities. Additionally, elimination of this program will create hardships not only to the individuals losing these services but also to their families who will be forced to shoulder the burden of caretaking. This will result in lost wages, potential job loss and increased household costs.

OPPOSE: Elimination of Adult Day Health Care.

4. **Alcohol and Drug funding and structure:**

Use the opportunity presented by the potential mental health program alignments to review ways in which mental health and substance use treatments and programs may be better integrated and collaboration between these systems is supported. Address the severe budget cuts that have produced alcohol and drug program funding cuts. Consider all potential changes with an emphasis on healthcare integration.

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SUPPORT: Integration of mental health, substance use disorder, and healthcare services.

5. **Low level state prisoners and youth authority inmates to county jails and probation:**

Set clear standards for county mental health and substance use disorder treatment and social support infrastructure that will provide services to these individuals with an appropriate rate; ensure appropriate access to psychiatric services and psychosocial treatments and supports.

SUPPORT: Clear standards of mental health and substance use disorder treatment and adequate funding for realigned criminal justice programs.

REALIGNMENT OF MENTAL HEALTH SERVICES

6. **Do no harm** to consumers in current programs and services.

In any before-and-after scenario of any changes to the structure, authority and funding of community mental health programs, the litmus test for our support is no existing or approved consumer services will be reduced or eliminated. i.e. their services should be of the same quality in all dimensions of treatment, care and support.

7. **Increase base funding** for the new mental health realignment.

Since the original realignment of mental health programs in 1991 it has become abundantly clear that the funding formula for the support of county mental health programs was inadequate. . The base rate formula for a new realigned mental health system needs to be increased enough to offset this historic inequity.

8. **Increase growth funding** for the new mental health realignment.

The 1991 realignment program provided for a growth account for excess money flowing into the realigned programs over and above the formula. A federal mandate gave welfare caseloads priority access to those growth funds. State mandates gave health programs the next highest priority. Mental Health programs, as a consequence, virtually never got a share of "growth." This must be addressed and rectified.

9. **One-time use of MHSA funds** to bridge programs to a new realigned mental health system at the county level.

If conditions 6-8 are met satisfactorily, then it might make sense to ease a transition into such a new realigned mental health system by the one-time use of MHSA funds. The redirected MHSA funds must be formalized as a loan to the state General Fund and there must be a clear written statement that there will be an overall net gain in funding for all county mental health programs in future years. **Quality of Care:** In any alteration of the MHSA, it will be important to ensure that quality of care standards and adequate care monitoring is in place in counties. Standards should include appropriate access to psychiatrists, appropriate rehabilitative supports, and integration with physical healthcare.

- **MHSA regulatory micromanagement:** Use this as an opportunity to review the thicket of obstructive MHSA micromanagement rules that have little to do with clinical needs in counties. Allow broader flexibility for use at local levels for critical problems.

For additional information please contact:

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